Primary Treating Physician's Permanent and Stationary Report (PR-4)

Insurance Name and Address: Joe Denham, 567 Insurance Blvd., Santa Rosa, CA 91840
Claim Number: 2346789XY
Employer Name: Ace Computers
Employer Address: 123, Employer City, CA 98756
Nature of Business: Computer/Tech
Patient Name: John M Doe
Sex: Male
Date of Birth: 11/01/1985
Patient Address: Employee Address, Employee City, CA 96570
Patient Telephone number: Home: (123) 456-7890 **Cell:** (123) 777-6666 **Work:** (123) 456-8900
Occupation: Computer/Tech - Computer Technician
Social Security Number: 123-45-6789
Injured at: 123, Employer City, CA 98756
Date of current exam: 11/15/2015
Date and Hour of Injury or Onset of Illness: 11/11/2015, 9:58 a.m.
Date Last Worked: 11/01/2015
Date and Hour of First Examination or Treatment: 11/15/2015

History of Injury/Illness:
Mr. John Doe is a right-handed 30 year-old male who worked at Ace Computers at the time of his injury. His industrial injury occurred on 11/11/2015. At the time of his injury, patient had worked 3 years at his job. The location of the injury/condition was the office. His right shoulder was injured due to lifting. The injury/condition was reported to: supervisor. After the injury occurred, he continued working.

Subjective Complaints
Mr. Doe and I discuss his current complaints.

Shoulder - Right
He describes his pain quality as aching. He describes the intensity of his pain as 2 out of 10. He rates the frequency of his pain as occurring 50% of the time. Rest, heat and movement make the pain better. Lifting, twisting and movement make the pain worse. For pain medication, Mr. Doe currently takes NSAIDs, Tylenol and muscle relaxants. The effect(s) of NSAIDS impacts the patient's signs, symptoms and ability to function. GI upset. Minor.

Activities of Daily Living We went over each of the 34 activities of daily living, self-care, personal hygiene, communication, physical activity, sensory function, non-specialized hand activities, travel, sexual functioning, and sleep.

Self-care, personal hygiene
The right shoulder causes pain during (but does not limit) the activities of brushing teeth, and dressing oneself. Difficulty putting on shirts and jackets.

Physical activity
The right shoulder limits the activities of sitting, and reclining. The right shoulder causes pain during (but does not limit) the activity of standing. Shoulder hurts when standing and hangs at side. Must use chair with arm rests. Cannot rest on shoulder on this side at all.

Non-specialized hand activities
The right shoulder limits the activity of lifting. Maximum lift 15#.

Sleep
The right shoulder limits the activities of restful, and nocturnal sleep patterns. Feels tired in am due to poor sleep. Awakens twice nightly.

Relevant Medical History
Med Trials to Date
Mr. Doe's medical trials to date include NSAIDs and muscle relaxants.

Therapy/Ancillary Treatments to Date
Mr. Doe has had 15 physical therapy treatments, 5 chiropractic treatments, 6 acupuncture treatments. The claim has involved durable medical equipment. Therabands.

Prior Care Facility/Case Consult Providers
Mr. Doe's prior care facility/case consult providers include orthopedics.

General Health Conditions/Past Medical History
We discuss his general health conditions and past medical history. He has remarkable prior illness of hypertension and asthma. He has a history of prior surgery. His prior surgery history includes cholecystectomy and tonsillectomy. He currently takes medication for hypertension and asthma. He has no known allergies.

General Review of Systems
Constitutional: Negative.
Eyes/vision: Negative.
Ears/Nose/Throat: Negative.
Cardiovascular/Heart/Circulation: Negative.
Respiratory/Breathing: Negative.
Gastrointestinal/Digestive: Negative.
Genitourinary/Urinary or Reproductive: Negative.
Musculoskeletal/Joints: Negative.
Skin: Negative.
Neurological/Dizziness/Weakness/Sensory: Negative.
Psychiatric/Depression/Anxiety/History of Suicidal Thoughts/Addictions: Negative.
Endocrine/Diabetes or Thyroid: Negative.
Hematological/Lymphatic/Bruising/Bleeding or Swollen Areas: Negative.
Allergic/Immunologic/Drug Intolerance etc: Positive. Current environmental allergies.

Surgery for this injury - Shoulder - Right

Surgery for this injury was performed on 12/01/2015. Dr. Schmidt. Subacromial decompression, claviculoplasty, and capsular release.

Social History

Mr. Doe and I talk about his social history. He tells me that he's married. At present, he is employed full time. His occupational history is remarkable for construction. Caffeine usage history is remarked as positive. 1/d. Alcohol usage history is remarked as positive. 0-1/wk. Mr. Doe's level of education is at the college level. He does not have a second job. Employee is not self-employed. Employee has no history of military service. His hobbies include computers, sports/hiking/exercise and outdoor activity. No functional limits from shoulder with regards to hobbies.

Objective Findings (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

General Exam

A general exam is performed. Mr. Doe's blood pressure is 115/67 mmHg. His heart rate is 76 beats per minute. His respiratory rate is 14 breaths per minute. He is 5 feet 10 inches tall. He weighs 167 pounds. His body mass index is calculated as 23.96 Kg/m2. Patient appears normal (not anxious, lethargic nor combative). A head exam is performed. No laceration, scarring, or deformity are present. Inspection and palpation of neck are normal. Inspection, palpation, percussion, and auscultation of the chest are normal. Normal cardiac inspection, palpation, and auscultation. The abdomen is examined, and inspection, auscultation, and percussion are normal. The skin exam is normal. No rash, tightening, ecchymosis or erythema in the areas examined.

Shoulder - Right

Inspect: No swelling/effusion, no erythema, no deformity, and surgical scars well healed.

Palpation: Tender; Greater tuberosity (humerus), bicepital groove, scapular spine and medial scapular border.

Shoulder Ranges of Motion Figure Table A1 page 596, Corrected with Errata March 2002: AMA Estimated Normal: Flexion (180D), Extension (40D), Abduction (180D), Adduction (30D), External Rotation (90), Internal Rotation (80D). Motion is measured with goniometer and is reported right over left side in Degrees (D).

Flexion: Right 155 D 147 D Left 180 D 179 D

Extension: Right 30 D 25 D Left 39 D 40 D

Abduction: Right 160 D 162 D Left 180 D 180 D

Adduction: Right 15 D 17 D Left 30 D 29 D

External Rotation: Right 37 D 38 D Left 78 D 81 D

Internal Rotation: Right 55 D 58 D Left 79 D 80 D

Shoulder Manual Muscle Testing: 5/5 all directions.

Special Testing: Impingement: positive. Instability: negative.

Distal Neurovascular Exam: Intact light touch, intact 5/5 motor and intact reflexes.

X-ray and Laboratory Results:

X-Ray

Shoulder - Right

Date: 11/11/2015. Acromion type. Type II. Arthritis/degenerative joint changes are present. Acromioclavicular joint; Severity is mild.

MRI

Shoulder - Right

Date: 11/30/2015. Arthritis/degenerative joint changes are present. Acromioclavicular is present; Severity is mild. Rotator cuff injuries are present. Infraspinatus. Tendinosis.

Diagnoses:
Essential (primary) hypertension. Non-industrial. ICD-10: I10.

Shoulder - Right
Strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder. Initial encounter. ICD-10: S46.011A.
Impingement syndrome of right shoulder. ICD-10: M75.41.
Primary osteoarthritis, right shoulder. ICD-10: M19.011.
Incomplete rotator cuff tear or rupture of right shoulder, not specified as traumatic. ICD-10: M75.111.
Sprain of right rotator cuff capsule. Subsequent encounter. ICD-10: S43.421D.
Adhesive capsulitis of right shoulder. ICD-10: M75.01.

Whole Person Impairment (WPI) rating using the AMA Guides 5th Edition

Shoulder - Right

Rating Chapter: 16 The Upper Extremities/ Shoulder

Amputations: (0%UEI)

Calculations: Table 16-4, Page 440.

Evaluating Abnormal Motion: (8%UEI)

Calculations: Section 1.5d Page 20, Section 16.4 Page 451, Section 16.4c Page 452-454, Figure 16-40 Page 476, Figure 16-43 Page 477, Figure 16-46 Page 479.

Peripheral Nerve Disorders: (0%UEI)

Calculations: Table 16-10 Page 482, Table 16-11 Page 484, Table 16-12a Page 485, Table 16-12b Page 486, Table 16-47 Page 487, Table 16-48 Page 488, Table 16-13 Page 489, Figure 16-49 Page 490, Figure 16-50 Page 490, Table 16-14 Page 490, Table 16-15 Page 492, Combining Values Chart Page 604-606.

Complex Regional Pain Syndromes (CRPS, CRPS 1, CRPS 2): (0%UEI)

Calculations: Table 16-16 Page 496. CRPS 1: Table 1-2 Page 4, Section 16.4 Pages 450-479, Table 16-10a Page 482, Table 16-12a Page 485, Table 16-13 Page 489, Figure 16-48 Page 488, Figure 16-49 Page 490, Figure 16-50 Page 490, Table 16-14 Page 490, Table 16-15 Page 492, Combining Values Chart Page 604-606. CRPS II: Section 16.4 Pages 450-479, Section 16.5, Table 16-10a Page 482, Table 16-12a Page 485, Table 16-13 Page 489, Figure 16-48 Page 488, Figure 16-49 Page 490, Figure 16-50 Page 490, Table 16-14 Page 490, Table 16-15 Page 492, Table 16-11 Page Table 16-13 Page 489, Table 16-14 Page 490, Table 16-15 Page 492, Combining Values Chart Page 604-606.

Vascular Disorders: (0%UEI)

Calculations: Table 16-17 Page 498.

Joint Swelling Due to Synovial Hypertrophy: (0%UEI)

Calculations: Table 16-18 Page 499, Table 16-19 Page 500.

Shoulder Instability: (0%UEI)

Calculations: Table 16-18 Page 499, Table 16-26 Page 505.

Arthroplasty: (10%UEI)

Calculations: Table 16-27 Page 506.

Manual Muscle Testing: (0%UEI)

Calculations: Table 16-11 Page 484, 16-35 Page 510.

Final: (17%UEI)

Calculations: Table 16-3 Page 439, Combining Values Chart Page 604-606.

Whole Person Impairment: 10% WPI
Shoulder - Right total: 10% **WPI**

Final Claim Summary

Shoulder - Right: 10% WPI

Final Impairment Rating: 10% WPI

Future Medical Treatment

Shoulder - Right
Treatment is indicated for the right shoulder. Access to medication should be made available in the future. In the future, therapy should be made available for this injury. Access to injections should be available in the future. Access to pain management is necessary today. For future care, additional access to pain management is required. Employee requires access to pain management specialty for physical medicine. A one time consult is requested for authorization. Theraband kit replacement. is required. Durable medical equipment is indicated.

Pain Related Impairment
According to Chapters 3-17 of the AMA Guides 5th Edition, no WPI (0%) is indicated.

Effects of Medication
NSAIDs: This medication is medically necessary to treat the shoulder symptoms. The use of this medication results in ongoing side effects. GI upset. Minor. As allowable in the glossary, "Effects of medication", Page 600, the impairment estimate is increased by 1% WPI.

Shoulder - Right
I assign 15% for imaging/degenerative changes. Total apportionment contribution for the right shoulder is 15%.

Functional Limitations
Return to clinic: Yes. 1 month. Employee can return to modified work on 11/19/2015 through 11/30/2015. I do not have a formal job description (RU-91 format) available for review.

Ability to Resume Usual and Customary Occupation
The employee can return to his occupation with the modifications described below.

Restricted Activities
The employee has work restrictions. Employee has work restrictions on lifting. He may lift items in the range of 0 - 10 lbs. He may lift occasionally for up to 3 hours per shift. The employee can perform lifting for 15 continuous minutes per hour.

Environmental Restrictions
The employee's environmental activities are not restricted.

Documentation
Clinic chart notes, consultant notes and imaging/diagnostic studies were reviewed. This information was necessary for the formulation of medical opinions.

I declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient or the preparation of this report. This report has been reviewed for internal consistency and compliance with the AMA Guides 5th Edition by Alchemy Logic Systems, Inc. Alchemy Logic Systems, Inc. dba RateFast is a California corporation owned by John W. Alchemy M.D. This evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code. I further declare under penalty of perjury that I personally performed the evaluation of the patient and I personally performed the cognitive services necessary to produce the report, and/or have reviewed this report and adopted the opinion herein as my own. I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted here in, that I believe it to be true.

Time Disclaimer
I verify under penalty of perjury that the total time I spend on the following activities is true and correct:
It took me 15 minutes to review the medical records.
I spent 20 minutes face-to-face time with the patient.
Complete preparation of this entire report took me 35 minutes.

e-signed by
Claire Williams, MD
11:37 p.m., January 19, 2016
Specialty: .

Invoicing information

	OMFS Code	Level	Unit(s)	Fee
E/M Est. Visit:	99213-17	3	1	$ 84.98
PR4 Page(s):	WC004-17		7	$ 181.48
Chart Review Pre-authorized:				
Report Preparation Pre-authorized:				
			Total	$ 266.46

(*Page calculation is based on DWC Form PR-4 (Rev. 06-05))

(hidden)	(hidden)	(hidden)	(hidden)	(hidden)	(hidden)

653 Alhambra St., Crockett, 94525, CA, US

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☑ New Request ☐ Resubmission - Change in Material Facts

☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health

☐ Check box if request is a written confirmation of a prior oral request.

Employee Information			
Name (Last, First, Middle): Doe John M			
Date of Injury (MM/DD/YYYY): 11/11/2015		Date of Birth (MM/DD/YYYY): 11/01/1985	
Claim Number: 2346789XY		Employer: Ace Computers	
Requesting Physician Information			
Name: Claire Williams			
Practice Name: Medicalpractice		Contact Name: Claire Williams	
Address: 653 Alhambra St., Crockett		City: Crockett	State: CA
Zip Code: 94525	Phone:	Fax Number:	
Specialty:		NPI Number:	
E-mail Address:			
Claims Administrator Information			
Company Name: Joe Denham		Contact Name: Jen Williams	
Address: 567 Insurance Blvd.		City: Santa Rosa	State: CA
Zip Code: 91840	Phone: (567) 890-3133 ext. 2	Fax Number: 3245678905	
E-mail Address: jen@fourfivesix.com			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration, Quantity, etc.)
Strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder Impingement syndrome of right shoulder Primary osteoarthritis, right shoulder Incomplete rotator cuff tear or rupture of right shoulder, not specified as traumatic Sprain of right rotator cuff capsule Adhesive capsulitis of right shoulder	Initial encounter. ICD-10: S46.011A. ICD -10: M75.41. ICD -10: M19.011. ICD -10: M75.111. Subsequent encounter. ICD-10: S43.421D. ICD -10: M75.01.	Theraband kit replacement.		

Theraband kit replacement. is required.

Requesting Physician Signature: Claire Williams, MD	Date: 01/19/16, 11:37 p.m.

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)

☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Zip Code:	Phone:	Fax Number:
Comments:		

Instructions for Request for Authorization Form

Warning: Private healthcare information is contained in the Request for Authorization for Medical Treatment, DWC Form RFA. The form can only go to other treating providers and to the claims administrator.

Overview: The Request for Authorization for Medical Treatment (DWC Form RFA) is required for the employee's treating physician to initiate the utilization review process required by Labor Code section 4610. A Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment must be attached. The DWC Form RFA is not a separately reimbursable report under the Official Medical Fee Schedule, found at California Code of Regulations, title 8, section 9789.10 et seq.

Checkboxes: Check the appropriate box at the top of the form. Indicate whether:

- This is a new treatment request for the employee or the resubmission of a previously denied request based on a change in material facts regarding the employee's condition. A resubmission is appropriate if the facts that provided the basis for the initial utilization review decision have subsequently changed such that the decision is no longer applicable to the employee's current condition. Include documentation supporting your claim.
- Review should be expedited based on an imminent and serious threat to the employee's health. A request for expedited review must be supported by documentation substantiating the employee's condition.
- The request is a written confirmation of an earlier oral request.

Routing Information: This form can be mailed, faxed, or e-mailed to the address, fax number, or e-mail address designated by the claims administrator for this purpose. The requesting physician must complete all identifying information regarding the employee, the claims administrator, and the physician.

Requested Treatment: The DWC Form RFA must contain all the information needed to substantiate the request for authorization. If the request is to continue a treatment plan or therapy, please attach documentation indicating progress, if applicable.

- List the diagnosis (required), the ICD Code (required), the specific service/good requested (required), and applicable CPT/HCPCS code (if known).
- Include, as necessary, the frequency, duration, quantity, etc. Reference to specific guidelines used to support treatment should also be included.
- For requested treatment that is: (a) inconsistent with the Medical Treatment Utilization Schedule (MTUS) found at California Code of Regulations, title 8, section 9792.20, et seq.; or (b) for a condition or injury not addressed by the MTUS, you may include scientifically based evidence published in peer-reviewed, nationally recognized journals that recommend the specific medical treatment or diagnostic services to justify your request.

Requesting Physician Signature: Signature/Date line is located under the requested treatment box. A signature by the treating physician is mandatory.

Claims Administrator/URO Response: Upon receipt of the DWC Form RFA, a claims administrator must respond within the timeframes and in the manner set forth in Labor Code section 4610 and California Code of Regulations, title 8, section 9792.9.1. To communicate its approval on requested treatment, the claims administrator may complete the lower portion

of the DWC Form RFA and fax it back to the requesting provider. (Use of the DWC Form RFA is optional when communicating approvals of treatment; a claims administrator may utilize other means of written notification.) If multiple treatments are requested, indicate in comments section if any individual request is being denied or referred to utilization review.